FINANCING PUBLIC HEALTH: INVESTMENT THAT WORKS FOR BETTER HEALTH SOLUTIONS

Financing is the Achilles Heel of our public health system—the enduring problem that makes it vulnerable. Public health programs rely on a complicated mix of federal, state and local funds. No single entity has overall responsibility to assure that the resources needed to protect the health of people are available or sufficient. There is no established level of funding and no stable revenue source to ensure that basic protection will remain in place when funding erodes at any level of government.

In 2002, the Finance Committee cited four key problems that must be overcome to assure an adequate level of protection in Washington:

- Public health is historically, persistently under-funded.
- Funding for core services is eroding, making the system very fragile.
- Investments vary widely from one county to the next, so protection is inconsistent.
- Categorical restrictions hamper efforts to respond to community needs.

No real progress has been made toward alleviating these problems during the past two years. The Finance Committee has accomplished some excellent work in this period, but the root causes for what ails public health lies beyond the committee's reach.

In 2004, the United Health Foundation published *America's Health: State Health Rankings*. The report placed Washington at 44th—near the bottom—for spending on public health. When many health factors were combined, our overall health ranking dropped from 11th in 2003 to 15th in 2004. Regarding the drop, the report said: "This indicates that the state may not improve its relative healthiness in the near future unless the risk factors are more aggressively addressed."

Continued erosion of core services and growing disparities

Spending for core public health activities—for basic services—has experienced the most pressure. Historically, Washington's counties and their city partners paid for core public health services such as water protection, food safety, and communicable disease prevention and control. State and federal funding were added to provide special programs. But over time, the categorical restrictions that came with state and federal funds created lopsided situations where special services—but not basic services—would be funded. Today, as county funds shrink, our ability to maintain core public health protection has severely eroded.

Public health services across the state are funded in a piecemeal fashion, with every county setting its own spending levels. Declining local revenues have forced local government to make hard budget cuts every year. For example, in the past 20 years, county spending

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on criminal justice programs has increased from 50% to 70% of county general fund outlays, leaving little money for public health or other local government services. After many years, this pattern leaves counties with uneven resources in disease control, environmental health protection, and health education.

Washington State has not established a basic level of funding for local public health protection. There is no minimum amount per citizen from the state or local government, nor a broad commitment to systemic investments in protection. The inconsistency in public health funding across the state is reflected in the amount of local contributions for public health per person, which ranges from $4.50 per year in some counties to $71.69 per year in others. It also shows up in basic staffing levels: 15 of Washington's local public health jurisdictions have fewer than 6 employees per 10,000 population. The range is from 1.8 to 29.

A Successful Public Health Investment: Tobacco Prevention

Anyone who doubts that spending on public health programs can save both lives and money should look at Washington's progress in battling the nation's No. 1 cause of preventable death: tobacco.

Since expansion of the state's Tobacco Prevention and Control Program in 2000, financed by resources from the national tobacco settlement and the state excise tax on cigarettes, the number of smokers in Washington has dropped by 12%—115,000 fewer people who suffer from the health, behavioral, and economic consequences of tobacco use. Washington's adult smoking rate of 19.7% is among the "lowest 10" of all the states and below the national median of 22%.

Since inception of the expanded program, Washington has invested about $90 million in tobacco prevention and control. This work has saved an estimated 38,000 lives from early tobacco-related deaths as well as $1.4 billion in future medical costs.

The program's four categories of activities—preventing youth from beginning to use tobacco, helping youth and adults quit, reducing exposure to secondhand smoke, and reducing tobacco use in high-risk groups—engages thousands of people throughout the state every day. More than 44,000 Washington residents have already called the state's "Tobacco Quit Line" (800-877-270-STOP). A media campaign warns children and youth, ages 8-18 years, of the dangers of smoking and exposure to secondhand smoke—on television and radio, in print, in convenience stores, and in recreation centers.

Considerable work in tobacco prevention is left to do. With nearly 1 in 5 of all adults still smoking, the state can expect tobacco-related diseases to kill 8,000 people every year. About 20,000 children and youth in Washington will begin smoking this year. Ten percent of pregnant women in the state still smoke during their last trimester. And Washington's $29 million annual investment in tobacco prevention is up against the $300 million the tobacco industry spends in the state every year to encourage people to smoke.

Prevention by the Numbers

It is impossible to put a dollar value on "health." But it is possible to calculate the economic impact of preventable health problems. Healthy People 2010, the set of national objectives that represent the U.S. "prevention agenda," includes an analysis of the how public health prevention activities save costs associated with unhealthy environments and behaviors. Among the costs that could be mitigated with prevention:

- 50,000 premature deaths and $40-50 billion in annual medical costs resulting from human exposure to outdoor air pollutants from all sources
- $3 billion each year in hospitalizations and from $20-40 billion a year in lost productivity associated with illness from microorganisms in food
- $55,000 to $155,000 or more per person in lifetime costs associated with HIV
- As much as $6,300 for first-year medical costs for every case of Lyme disease that isn't caught in the early stage
- 55,000 cases, 11,000 hospitalizations, 120 deaths, and $100 million in direct medical costs associated with a measles resurgence in the United States during 1989-91
- $224 billion in annual costs related to preventable injuries
- $6,200 in average hospital costs for each low-birthweight birth, compared to $1,900 for a normal, healthy delivery
- $200 billion a year for medical expenses and lost productivity associated with poor nutrition
- $6 billion in medical expenditures and lost productivity related to asthma
- 430,000 deaths a year and $50 billion in direct medical costs associated with tobacco use

Health impacts of declining resources

Washington's public health workers have shouldered the burden in lean times and shown that they can do more with less. But the size of our public health workforce has remained basically static during the past 10 years, while the workload has been growing. Public health managers today are quick to state that the system has reached a breaking point. Unreasonable workloads and staff burn-out are direct outcomes. The health impacts will come later, as a faltering system must contend with complex problems. These include the re-emergence of resistant strains of diseases such as tuberculosis, syphilis, and staph; the emergence of global infections such as SARS; the specter of catastrophic events such as mad cow disease, and the additional responsibility of becoming one of the first responders to acts of bioterrorism.

The cost of lost opportunities is even greater, though difficult to see. With the workforce pared down and constantly responding to urgent situations, investments in prevention get pushed aside, despite their promising potential. Washington's special efforts in tobacco have reaped huge rewards (see box, previous page). We could lessen the toll of later, high medical care costs if similar investments were made in early childhood screening, physical activity, nutrition, environmental health protection, and early intervention for mental health and substance abuse.

Today, less that 1% of the nation's $1.5 trillion health tab is directed toward public health measures, despite the fact that they are proven to be effective and offer greater return on investment than medical care (see box, above). What is needed is a formal national and statewide "prevention agenda" that demands increased prevention investments for every public dollar spent on medical care.

Estimating costs of adequate public health protection

What should we be spending on public health in Washington? With publication of the *Standards for Public Health in Washington State* in 2001, the Finance Committee and the Standards

Spending Too Much on Health Care—but Not Enough on *Health*?

U.S. spending on health has reached $1.5 trillion annually. But the way we spend this money does not logically follow the factors that we know determine our health.

For example, a Priorities of Government group considering health expenditures in Washington State has adopted a set of recommended priority strategies that is based on the determinants of health (see page 17). But it saw major discrepancies between these priorities and where state health dollars actually go. Some examples:

- *Our behavior* accounts for about 40% of how healthy we are, but state spending to support healthy behavior is only about 2.5% of the overall health budget.
- *Our surroundings*—environment and social circumstances—account for about 20% of our health, but we spend about 2.8% of our health budget in these areas.
- *Medical care* contributes only about 10% to our overall health, but it consumes about 95% of Washington's state health budget.

Medical care is essential, and seeing that all who need it have access is a core function of public health. But medical costs are rising far faster than either government, payers, or consumers can afford. If we invested more in preventive measures, we might be able to reduce spending on health care to affordable levels.

Source: Projected expenditures, 2005-07 biennial budget, based on Washington State Department of Health Priorities of Government Health Committee

Committee were able to join forces to determine the cost of providing the services that all Washington residents have a right to expect from their public health system. In effect, the two committees have worked to "cost" the standards at about a 95 percent performance level—a level the committee members considered to be realistic.

The joint committee created three "cost models" that capture the specific responsibilities of state, local, and metropolitan public health jurisdictions. Each of these models is based on clearly defined assumptions. To guide this work, the Finance Committee developed a list of essential public health activities—those necessary to the public's health and that should be provided by public health agencies if there is no one else in the community to do it—and organized the services according to the standards framework (see Appendix 6).

To meet the standards for public health statewide, the committee estimates it would take additional investments of $400 million per year—with most of that, $385 million, spent at the local level. While this amount is roughly double what we now spend at the local level, it remains only a few cents on the dollar for what is spent every day for medical care services *after* people have become ill with an infectious disease, a chronic condition, or a mental illness.

Based on reports from the U.S. Department of Health and Human Services and reports on public health spending in Washington State:

- Medical care spending is roughly $4,370 per capita, per year.
- Public health spending is roughly $98 per capita, per year.
- If fully funded to meet the standards, public health spending would be $163 per capita, per year.

The cost estimate work creates a rational framework for funding public health, but alone, it does not achieve the goal of a "stable and sufficient" financing system for public health that the first PHIP called for in 1994. Meeting that goal will require a collective effort among

state and local elected officials, public health agencies, and their community partners to provide needed resources and to identify new funding sources. In recognition of this necessary next step, the Finance Committee will draft a white paper on public health financing that describes our current system's strengths and weaknesses and encourages policy makers to explore potential new funding sources.

Improving the way we manage funding

Although the Finance Committee cannot change national investment strategy, it has elected to work on some issues that will improve quality in our state's system. The committee has identified ways to spend the system's limited dollars more efficiently by examining the complex flow of categorical funds from the federal government to the state and on to local public health jurisdictions. It has developed templates that will provide a standardized process for allocating funds and established criteria for reviewing and updating funding allocation formulas. The committee also drafted principles for funding allocations, so that available funds will be distributed in an equitable and predictable manner (see Appendix 9). This work will help state and local health officials make reasonable decisions about how best to allocate limited resources.

Recommendations for 2005-07

1. Increase public health funding by $400 million to close the funding gaps identified in the Finance Committee's cost model.

   Stable and sufficient sources of funding are essential to maintaining a sound public health system. All residents need and expect a predictable level of public health protection.

2. Expand the Finance Committee to include broader representation by state and local stakeholders, to help identify opportunities to articulate the importance of fully funding our public health system, to explore viable state funding options, and to get this information to decision-makers.

   Active involvement by concerned citizens and policy makers is critical to solving the chronic funding instability that plagues public health. The Steering Committee will look to a specially organized group to study alternative financing strategies and seek solutions that will work, statewide.

3. Implement the work of the Funding Allocations Subcommittee to make certain that allocation formulas are clear and all funding for programs is easily tracked on a website.

   Given scarce resources, every dollar in public health needs to be used efficiently. The Finance Committee will continue to work to improve funding practices to achieve a common understanding of allocation principles and how they are used. Additional work will be pursued on statewide program evaluation and on clarifying data needs so that required program reports are as simple as possible, yet support accountability measures, program evaluation, and where feasible, needed research.